907 KAR 1:160. Home and community based waiver services version 1.

RELATES TO: KRS 205.520(3), 205.5605, 205.5606, 205.5607, 205.635, 42 C.F.R. 440.180

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.5606, 42 C.F.R. 440.180, 42 U.S.C. 1396a, 1396b, 1396d, 1396n

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the provisions for home and community based waiver services version 1, including participant-directed services pursuant to KRS 205.5606.

Section 1. Definitions.

(1) "1915(c) home and community based services waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(2) "Abuse" regarding:

(a) An adult is defined by KRS 209.020(8); or

(b) A child means abuse pursuant to KRS Chapter 600 or 620.

(3) "ADHC" means adult day health care.

(4) "ADHC center" means an adult day health care center licensed in accordance with 902 KAR 20:066.

(5) "ADHC services" means health-related services provided on a regularly-scheduled basis that ensure optimal functioning of a participant who:

(a) Does not require twenty-four (24) hour care in an institutional setting; and

(b) May need twenty-four (24) hour respite services when experiencing a short-term crisis due to the temporary or permanent loss of the primary caregiver.

(6) "Advanced practice registered nurse" or "APRN" is defined by KRS 314.011(7).

(7) "Assessment team" means a team that:

(a) Conducts assessment or reassessment services; and

(b) Consists of:

1. Two (2) registered nurses; or

2. One (1) registered nurse and one (1) of the following:

a. A certified social worker;

b. A certified psychologist with autonomous functioning;

c. A licensed psychological practitioner;

d. A licensed marriage and family therapist;

e. A licensed professional clinical counselor;

f. A licensed social worker; or

g. A licensed clinical social worker.

(8) "Blended services" means a non-duplicative combination of HCB waiver services identified in Section 5 of this administrative regulation and PDS identified in Section 6 of this administrative regulation provided pursuant to a recipient's approved plan of care.

(9) "Budget allowance" is defined by KRS 205.5605(1).

(10) "Certified psychologist with autonomous functioning" or "licensed psychological practitioner" means a person licensed pursuant to KRS Chapter 319.

(11) "Certified social worker" means an individual who meets the requirements established in KRS 335.080.

(12) "Chemical restraint" means a drug or medication:

(a) Used to restrict an individual's:

1. Behavior; or

2. Freedom of movement; and

(b)

1. That is not a standard treatment for the individual's condition; or

2. Dosage that is not an appropriate dosage for the individual's condition.

(13) "Communicable disease" means a disease that is transmitted:

(a) Through direct contact with an infected individual;

(b) Indirectly through an organism that carries disease-causing microorganisms from one (1) host to another or a bacteriophage, a plasmid, or another agent that transfers genetic material from one (1) location to another; or

(c) Indirectly by a bacteriophage, a plasmid, or another agent that transfers genetic material from one (1) location to another.

(14) "Covered services and supports" is defined by KRS 205.5605(3).

(15) "DCBS" means the Department for Community Based Services.

(16) "Department" means the Department for Medicaid Services or its designee.

(17) "Electronic signature" is defined by KRS 369.102(8).

(18) "Exploitation" regarding:

(a) An adult is defined by KRS 209.020(9); or

(b) A child means exploitation pursuant to KRS Chapter 600 or 620.

(19) "Home and community based waiver services" or "HCB waiver services" means home and community based waiver services:

(a) For individuals who meet the requirements of Section 4 of this administrative regulation; and

(b) Covered by the department pursuant to this administrative regulation.

(20) "Home and community support services" means nonresidential and nonmedical home and community based services and supports that:

(a) Meet the participant's needs; and

(b) Constitute a cost-effective use of funds.

(21) "Home health agency" means an agency that is:

(a) Licensed in accordance with 902 KAR 20:081; and

(b) Medicare and Medicaid certified.

(22) "Illicit drug" means:

(a) A drug, prescription or not prescription, used illegally or in excess of therapeutic levels; or

(b) A prohibited drug.

(23) "Licensed clinical social worker" means an individual who meets the requirements established in KRS 335.100.

(24) "Licensed marriage and family therapist" or "LMFT" is defined by KRS 335.300(2).

(25) "Licensed practical nurse" or "LPN" means a person who:

(a) Meets the definition established by KRS 314.011(9); and

(b) Works under the supervision of a registered nurse.

(26) "Licensed professional clinical counselor" or "LPCC" is defined by KRS 335.500(3).

(27) "Licensed social worker" means an individual who meets the requirements established in KRS 335.090.

(28) "Neglect" regarding:

(a) An adult is defined by KRS 209.020(16); or

(b) A child means neglect pursuant to KRS Chapter 600 or 620.

(29) "NF" means nursing facility.

(30) "NF level of care" means a high intensity or low intensity patient status determination made by the department in accordance with 907 KAR 1:022.

(31) "Normal baby-sitting" means general care provided to a child that includes custody, control, and supervision.

(32) "Occupational therapist" is defined by KRS 319A.010(3).

(33) "Occupational therapy assistant" is defined by KRS 319A.010(4).
(34) "Participant" means a recipient who meets the:
(a) NF level of care criteria established in 907 KAR 1:022; and
(b) Eligibility criteria for HCB waiver services established in Section 4 of this administrative regulation.
(35) "Patient liability" means the financial amount an individual is required to contribute toward cost of care in order to maintain Medicaid eligibility.
(36) "PDS" means participant-directed services.
(37) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment that:
(a) Immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely; and
(b) Does not include:
1. Orthopedically prescribed devices or other devices, surgical dressings or bandages, or protective helmets; or
2. Other methods that involve the physical holding of a person for the purpose of:
a. Conducting routine physical examinations or tests;
b. Protecting the person from falling out of bed; or
c. Permitting the person to participate in activities without the risk of physical harm.
(38) "Physical therapist" is defined by KRS 327.010(2).
(39) "Physical therapist assistant" means a skilled health care worker who:
(a) Is certified by the Kentucky Board of Physical Therapy; and
(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.
(40) "Physician assistant" or "PA" is defined by KRS 311.840(3).
(41) "Plan of care" or "POC" means a written individualized comprehensive plan that:
(a) Encompasses all HCB waiver services; and
(b) Is developed by a participant or a participant's legal representative, case manager, or other individual designated by the participant.
(42) "Plan of treatment" means a care plan developed and used by an ADHC center based on the participant's individualized ADHC service needs, goals, interventions, and outcomes.
(43) "Prohibited drug" means a drug or substance that is illegal under KRS Chapter 218A.
(44) "Registered nurse" or "RN" means a person who:
(a) Meets the definition established by KRS 314.011(5); and
(b) Has one (1) year or more experience as a professional nurse.
(45) "Representative" is defined by KRS 205.5605(6).
(46) "Sex crime" is defined by KRS 17.165(1).
(47) "Speech-language pathologist" is defined by KRS 334A.020(3).
(48) "Support broker" means an individual chosen by a participant from an agency designated by the department to:
(a) Provide training, technical assistance, and support to a participant; and
(b) Assist a participant in any other aspects of PDS.
(49) "Support spending plan" means a plan for a participant that identifies the:
(a) PDS requested;
(b) Employee name;
(c) Hourly wage;
(d) Hours per month;
(e) Monthly pay;
(f) Taxes; and

(g) Budget allowance.

(50) "Violent crime" is defined by KRS 17.165(3).

(51) "Violent offender" is defined by KRS 17.165(2).

Section 2. Provider Participation.

(1) In order to provide HCB waiver services version 1, excluding participant-directed services, an HCB waiver provider shall be a home health agency or ADHC center that provides services:

(a) Directly; or

(b) Indirectly through a subcontractor.

(2) An out-of-state provider shall comply with the requirements of this administrative regulation.

(3) An HCB waiver provider:

(a) Shall comply with the following administrative regulations and program requirements:

1. 902 KAR 20:081;
2. 907 KAR 1:671;
3. 907 KAR 1:672;
4. 907 KAR 1:673;
5. The Department for Medicaid Services Home and Community Based Waiver Services Manual; and
6. The Department for Medicaid Services Adult Day Health Care Services Manual;

(b) Shall not enroll a participant for whom the provider cannot provide HCB waiver services;

(c) Shall choose to accept or not accept a participant;

(d) Shall implement a procedure to ensure that the following is reported:

1. Abuse, neglect, or exploitation of a participant in accordance with KRS Chapters 209 or 620;
2. A slip or fall;
3. A transportation incident;
4. Improper administration of medication;
5. A medical complication; or
6. An incident caused by the recipient, including:
   a. Verbal or physical abuse of staff or other recipients;
   b. Destruction or damage of property; or
   c. Recipient self-abuse;

(e) Shall ensure a copy of each incident report required by paragraph (d) of this subsection is maintained in a central file subject to review by the department;

(f) Shall implement a process for communicating the incident, the outcome, and the prevention plan to:

1. The participant, family member, or responsible party; and
2. The attending physician, PA, or APRN;

(g) Shall maintain documentation of any communication provided in accordance with paragraph (f) of this subsection. The documentation shall be:

1. Recorded in the participant's case record; and
2. Signed and dated by the staff member making the entry;

(h) Shall implement a procedure that ensures the reporting of a participant or any interested party's complaint against the provider or its personnel to the provider agency or facility;

(i) Shall ensure that a copy of each complaint reported is maintained in a central file subject to review by the department;

(j) Shall implement a process for communicating a complaint, the resulting outcome, and related prevention plan to:
1. The participant, family member, or the participant's responsible party; and
2. The attending physician, PA, or APRN if appropriate;
(k) Shall maintain documentation of any communication provided in accordance with paragraph (j) of this subsection. The documentation shall be:
1. Recorded in the participant's case record; and
2. Signed and dated by the staff member making the entry;
(l) Shall inform a participant or any interested party in writing of the provider's:
1. Hours of operation; and
2. Policies and procedures;
(m) Shall not permit a staff member who has contracted a communicable disease to provide a service to a participant until the condition is determined to no longer be contagious;
(n) Shall ensure that a staff member who provides direct services:
1. Demonstrates the ability to:
a. Read;
b. Write;
c. Understand and carry out instructions;
d. Keep simple records; and
e. Interact with a participant when providing an HCB waiver service;
2. Is trained by an HCB waiver provider; and
3. Is supervised by an RN at least every other month;
(o) Shall ensure that each staff person:
1. Prior to independently providing a direct service, is trained regarding:
a. Abuse, neglect, fraud, and exploitation;
b. The reporting of abuse, neglect, fraud, and exploitation;
c. Person-centered planning principles;
d. Documentation requirements; and
e. HCB services definitions and requirements;
2. Receives cardio pulmonary resuscitation certification and first aid certification provided by a nationally accredited entity within six (6) months of employment;
3. Maintains current CPR certification and first aid certification for the duration of the staff person's employment;
4.
a. Completes a tuberculosis (TB) risk assessment performed by a licensed medical professional within the past twelve (12) months and annually thereafter; and
b.
(i) If a TB risk assessment resulted in a TB skin test being performed, have a negative result within the past twelve (12) months as documented on test results received by the provider within thirty (30) days of the date of hire; and
(ii) If it is determined that signs or symptoms of active disease are present, in order for the person to be allowed to work, be administered follow-up testing by his or her physician or physician assistant with the testing indicating the person does not have active TB disease; and
5. Prior to the beginning of employment, has successfully passed a drug test with no indication of prohibited or illicit drug use;
(p)
1. Shall:
a. Prior to hiring an individual, obtain:
(i) The results of a criminal record check from the Kentucky Administrative Office of the Courts and equivalent out-of-state agency if the individual resided

or worked outside of Kentucky during the twelve (12) months prior to employment;

(ii) The results of a Nurse Aide Abuse Registry check as described in 906 KAR 1:100 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and

(iii) The results of a Caregiver Misconduct Registry check as described in 922 KAR 5:120 and equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; and

b. Within thirty (30) days of the date of hire, obtain the results of a Central Registry check as described in 922 KAR 1:470 and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment; or

2. May use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of subparagraph 1 of this paragraph; and

(q) Shall not allow a staff person to provide HCB waiver services if the individual:

1. Has a prior conviction of or pled guilty to a:
   a. Sex crime; or
   b. Violent crime;
2. Is a violent offender;
3. Has a prior felony conviction;
4. Has a drug related conviction, felony plea bargain, or amended plea bargain conviction within the past five (5) years;
5. Has a positive drug test for an illicit or a prohibited drug;
6. Has a conviction of abuse, neglect, or exploitation;
7. Has a Cabinet for Health and Family Services finding of:
   a. Child abuse or neglect pursuant to the Central Registry as described in 922 KAR 1:470; or
   b. Adult abuse, neglect, or exploitation pursuant to the Caregiver Misconduct Registry as described in 922 KAR 5:120;
8. Is listed on the Nurse Aide Abuse Registry pursuant to 906 KAR 1:100;
9. Within the twelve (12) months prior to employment, is listed on or has a finding indicated on another state's equivalent of the:
   a. Nurse Aide Abuse Registry as described in 906 KAR 1:100 if the other state has an equivalent;
   b. Caregiver Misconduct Registry as described in 922 KAR 5:120 if the other state has an equivalent; or
   c. Central Registry as described in 922 KAR 1:470 if the other state has an equivalent; or
10. Has been convicted of Medicaid or Medicare fraud.

Section 3. Maintenance of Records.

(1) An HCB waiver provider shall maintain:

(a) A clinical record for each participant. The clinical record shall contain the following:

1. Pertinent medical, nursing, and social history;
2. A comprehensive assessment entered on form MAP-351, Medicaid Waiver Assessment and signed by the:
   a. Assessment team; and
   b. Department;
3. A completed MAP 109, Plan of Care/Prior Authorization for Waiver Services;

4. A copy of the MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form signed by the participant or participant's legal representative at the time of application or reapplication and each recertification thereafter;
5. The name of the case manager;
6. Documentation of all level of care determinations;
7. All documentation related to prior authorizations, including requests, approvals, and denials;
8. Documentation of each contact with, or on behalf of, a participant;
9. Documentation that the participant receiving ADHC services was provided a copy of the ADHC center's posted hours of operation;
10. Documentation that the participant or legal representative was informed of the procedure for reporting complaints; and
11. Documentation of each service provided that shall include:
a. The date the service was provided;
b. The duration of the service;
c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the participant's home;
d. Itemization of each personal care or homemaking service delivered;
e. The participant's arrival and departure time, excluding travel time, if the service was provided at the ADHC center;
f. Progress notes, which shall include documentation of changes, responses, and treatments utilized to evaluate the participant's needs; and
g. The name, title, and signature of the service provider; and

(b)
1. Fiscal reports regarding services provided, service records regarding services provided, and incident reports. These reports shall be retained:
a. At least six (6) years from the date that a covered service is provided; or
b. For a minor, three (3) years after the recipient reaches the age of majority under state law, whichever is longest.
2. If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in subparagraph 1. of this paragraph, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(2) Upon request, an HCB waiver provider shall make information regarding service and financial records available to the:
(a) Department;
(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;
(c) Department for Health and Human Services or its designee;
(d) General Accounting Office or its designee;
(e) Office of the Auditor of Public Accounts or its designee; or
(f) Office of the Attorney General or its designee.

Section 4. Participant Eligibility Determinations and Redeterminations.
(1) An HCB waiver service shall be provided to a Medicaid eligible participant who:
(a) Is determined by the department to meet NF level of care requirements; and
(b) Would, without waiver services, be admitted by a physician's order to an NF.
(2) The department shall perform an NF level of care determination for each participant at least once every twelve (12) months or more often if necessary.
(3) An HCB waiver service shall not be provided to an individual who:
(a) Does not require a service other than:

1. A minor home adaptation;
2. Case management; or
3. A minor home adaptation and case management;

(b) Is an inpatient of:
1. A hospital;
2. An NF; or
3. An intermediate care facility for individuals with an intellectual disability;

(c) Is a resident of a licensed personal care home; or

(d) Is receiving services from another 1915(c) home and community based services waiver program.

(4) An HCB waiver provider shall:

(a) Inform a participant or the participant's legal representative of the choice to receive:
1. HCB waiver services; or
2. Institutional services; and

(b) Require a participant to sign a MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form at the time of application or reapplication and at each recertification to document that the individual was informed of the choice to receive HCB waiver or institutional services.

(5) An eligible participant or the participant's legal representative shall select a participating HCB waiver provider from which the participant wishes to receive HCB waiver services.

(6) An HCB waiver provider shall use a MAP-24, Memorandum to notify the local DCBS office and the department of a participant's:

(a) Termination from the HCB waiver program; or

(b)
1. Admission to an NF for less than sixty (60) consecutive days; and
2. Return to the HCB waiver program from an NF within sixty (60) consecutive days.

Section 5. Covered Services.

(1) An HCB waiver service shall:

(a) Be prior authorized by the department to ensure that the service or modification of the service already meets the needs of the participant;

(b) Be provided pursuant to a plan of care or, for a PDS, pursuant to a plan of care and support spending plan;

(c) Except for a PDS, not be provided by a member of the participant's family. A PDS may be provided by a participant's family member; and

(d) Be accessed within sixty (60) days of the date of prior authorization.

(2) To request prior authorization, a provider shall submit a completed MAP 10, Waiver Services Physician's Recommendation; MAP 109, Plan of Care/Prior Authorization for Waiver Services; and MAP 351, Medicaid Waiver Assessment to the department.

(3) Covered HCB services shall include:

(a) A comprehensive assessment, which shall:

1. Identify a participant's needs and the services that the participant or the participant's family cannot manage or arrange for on the participant's behalf;

2. Evaluate a participant's physical health, mental health, social supports, and environment;

3. Be requested by an individual seeking HCB waiver services or the individual's family, legal representative, physician, physician assistant, or APRN;

4. Be conducted by an assessment team within seven (7) calendar days of receipt of the request for assessment; and

5. Include at least one (1) face-to-face home visit by a member of the assessment team with the participant and, if appropriate, the participant's family;

(b) A reassessment service, which shall:

1. Determine the continuing need for HCB waiver services and, if appropriate, PDS;
2. Be performed at least every twelve (12) months;
3. Be conducted using the same procedures used in an assessment service;
4. Not be retroactive; and
5. Be initiated by an HCB waiver provider or support broker who shall:
   a. Notify the department no more than three (3) weeks prior to the expiration of the current level of care certification to ensure that certification is consecutive; and
   b. Not be reimbursed for a service provided during a period that a participant is not covered by a valid level of care certification;

(c) A case management service, which shall:

1. Consist of coordinating the delivery of direct and indirect services to a participant;
2. Be provided by a case manager who shall:
   a. Be an RN, LPN, certified social worker, certified psychologist with autonomous functioning, licensed psychological practitioner, LMFT, licensed clinical social worker, licensed social worker, or an LPCC;
   b. Arrange for a service but not provide a service directly;
   c. Contact the participant monthly by telephone or through a face-to-face visit at the participant's residence or in the ADHC center, with a minimum of one (1) face-to-face visit between the case manager and the participant every other month; and
   d. Assure that service delivery is in accordance with a participant's plan of care;
3. Not include a group conference; and
4. Include development of a plan of care that shall:
   a. Be completed on the MAP 109, Plan of Care/Prior Authorization for Waiver Services;
   b. Reflect the needs of the participant;
   c. List goals, interventions, and outcomes;
   d. Specify services needed;
   e. Determine the amount, frequency, and duration of services;
   f. Provide for reassessment at least every twelve (12) months;
   g. Be developed and signed by the assessment team, case manager, and participant or participant's family; and
   h. Be submitted to the department no later than thirty (30) calendar days after receiving the department's verbal approval of NF level of care;

(d) A homemaker service, which shall consist of general household activities and shall be provided:

1. By staff pursuant to Section 2(3)(m) and (n) of this administrative regulation; and
2. To a participant:
   a. Who is functionally unable, but would normally perform age-appropriate homemaker tasks; and
   b. If the caregiver regularly responsible for homemaker activities is temporarily absent or functionally unable to manage the homemaking activities;

(e) A personal care service, which shall consist of age-appropriate medically-oriented services and be provided:

1. By staff pursuant to Section 2(3)(m) and (n) of this administrative regulation; and
2. To a participant:
   a. Who does not need highly skilled or technical care;

b. For whom services are essential to the participant's health and welfare and not for the participant's family; and

c. Who needs assistance with age-appropriate activities of daily living;

(f) An attendant care service, which shall consist of hands-on care that is:

1. Provided by staff pursuant to Section 2(3)(m) and (n) of this administrative regulation to a participant who:

a. Is medically stable but functionally dependent and requires care or supervision twenty-four (24) hours per day; and

b. Has a family member or other primary caretaker who is employed and not able to provide care during working hours;

2. Not of a general housekeeping nature; and

3. Not provided to a participant who is receiving any of the following HCB waiver services:

a. Personal care;

b. Homemaker; or

c. ADHC;

(g) A respite care service, which shall be short term care based on the absence or need for relief of the primary caretaker and be:

1. Provided by staff pursuant to Section 2(3)(m) and (n) of this administrative regulation who provide services at a level that appropriately and safely meets the medical needs of the participant in the following settings:

a. A participant's place of residence; or

b. An ADHC center during posted hours of operation;

2. Provided to a participant who has care needs beyond normal baby-sitting;

3. Used no less than every six (6) months; and

4. Provided in accordance with 902 KAR 20:066;

(h) A minor home adaptation service, which shall be a physical adaptation to a home that is necessary to ensure the health, welfare, and safety of a participant, and which shall:

1. Meet all applicable safety and local building codes;

2. Relate strictly to the participant's disability and needs;

3. Exclude an adaptation or improvement to a home that has no direct medical or remedial benefit to the participant; and

4. Be submitted on form MAP-95 Request for Equipment Form for prior authorization; or

(i) An ADHC service, which shall:

1. Except for a participant approved for an ADHC service prior to May 1, 2003, be provided to a participant who is at least twenty-one (21) years of age;

2. Include the following basic services and necessities provided to participants during the posted hours of operation:

a. Skilled nursing services provided by an RN or LPN, including ostomy care, urinary catheter care, decubitus care, tube feeding, venipuncture, insulin injections, tracheotomy care, or medical monitoring;

b. Meal service corresponding with hours of operation with a minimum of one (1) meal per day and therapeutic diets as required;

c. Snacks;

d. The presence of an RN or LPN;

e. Age and diagnosis appropriate daily activities; and

f. Routine services that meet the daily personal and health care needs of a participant, including:

(i) Monitoring of vital signs;

(ii) Assistance with activities of daily living; and

(iii) Monitoring and supervision of self-administered medications, therapeutic programs, and incidental supplies and equipment needed for use by a participant;

3. Include developing, implementing, and maintaining nursing policies for nursing or medical procedures performed in the ADHC center;

4. Include ancillary services in accordance with 907 KAR 1:023, if ordered by a physician, PA, or APRN in a participant's ADHC plan of treatment. Ancillary services shall:

a. Consist of evaluations or reevaluations for the purpose of developing a plan, which shall be carried out by the participant or ADHC center staff;

b. Be reasonable and necessary for the participant's condition;

c. Be rehabilitative in nature;

d. Include physical therapy provided by a physical therapist or physical therapist assistant, occupational therapy provided by an occupational therapist or occupational therapy assistant, or speech therapy provided by a speech-language pathologist; and

e. Comply with the physical, occupational, and speech therapy requirements established in Technical Criteria for Reviewing Ancillary Services for Adults;

5. Include respite care services pursuant to paragraph (g) of this subsection;

6. Be provided to a participant by the health team in an ADHC center, which may include:

a. A physician;

b. A physician assistant;

c. An APRN;

d. An RN;

e. An LPN;

f. An activities director;

g. A physical therapist;

h. A physical therapist assistant;

i. An occupational therapist;

j. An occupational therapy assistant;

k. A speech-language pathologist;

l. A certified social worker;

m. A licensed clinical social worker;

n. A nutritionist;

o. A health aide;

p. An LPCC;

q. An LMFT;

r. A certified psychologist with autonomous functioning;

s. A licensed psychological practitioner; or

t. A licensed social worker; and

7. Be provided pursuant to a plan of treatment. The plan of treatment shall:

a. Be developed and signed by each member of the plan of treatment team, which shall include the participant or a legal representative of the participant;

b. Include pertinent diagnoses, mental status, services required, frequency of visits to the ADHC center, prognosis, rehabilitation potential, functional limitation, activities permitted, nutritional requirements, medication, treatment, safety measures to protect against injury, instructions for timely discharge, and other pertinent information; and

c. Be developed annually from information on the MAP 351, Medicaid Waiver Assessment and revised as needed.

(4) Modification of an ancillary therapy service or an ADHC unit of service shall require prior authorization as established in this subsection.

(a) Prior authorization shall:

1. Be requested by an RN or designated ADHC center staff; and
2. Require submission of a revised MAP 109, Plan of Care/Prior Authorization for Waiver Services and an order signed by a physician, physician assistant, or APRN.

(b) An RN or designated ADHC center staff shall forward a copy of the documents required in paragraph (a) of this subsection to the HCB case manager or the participant's support broker for inclusion in the participant's case records within ten (10) working days of the prior authorization request.

(c) Upon approval or denial of a prior authorization request, the department shall provide written notification to the HCB agency, the ADHC center, and the participant.

(d) The case manager or support broker shall:

1. Inform the ADHC center of approval or denial; and
2. Document the approval or denial in the case record.

(5)

(a) An ADHC center shall maintain a sign in and out log documenting the provision of services to participants.

(b) Documentation shall include:

1. The date the service was provided;
2. The duration of the service;
3. The arrival and departure time of the participant;
4. A description of the service provided; and
5. The title and signature of the staff who provided the service.

Section 6. Participant-Directed Services.

(1) Covered services and supports provided to a participant participating in PDS shall include:

(a) Home and community support services, which shall:

1. Be available only under the participant-directed services;
2. Be provided in the participant's home or in the community;
3. Be based upon therapeutic goals and not be divisional in nature; and
4. Not be provided to a participant if the same or similar service is being provided to the participant via non-PDS HCB waiver services; or

(b) Goods and services, which shall:

1. Be individualized;
2. Meet identified needs required by the participant's plan of care that are necessary to ensure the health, welfare, and safety of the participant;
3. Be items or minor adaptations that are utilized to reduce the need for personal care or to enhance independence within the home or community of the participant;
4. Not include experimental goods or services; and
5. Not include chemical or physical restraints.

(2) To be covered, a PDS shall be specified in the plan of care.

(3) Reimbursement for a PDS shall not exceed the department's allowed reimbursement for the same or similar service provided in a non-PDS HCB setting.

(4) A participant, including a married participant, shall choose providers and a participant's choice shall be reflected or documented in the plan of care.

(5)

(a) A participant may designate a representative to act on the participant's behalf.

(b) A PDS representative shall:

1. Be twenty-one (21) years of age or older;

2. Not be monetarily compensated for acting as the PDS representative or providing a PDS;

3. Be appointed by the participant on a MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS);

4. Comply with the requirements for background and related checks established in Section 2(3)(p) of this administrative regulation; and

5. Not be a PDS representative if found in violation of any of the provisions established in subsection (11)(i) of this section.

(6) A participant may voluntarily terminate PDS by completing a MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS) and submitting it to the support broker.

(7) The department shall immediately terminate a participant from PDS if:

(a) Imminent danger to the participant's health, safety, or welfare exists;

(b) The participant fails to pay patient liability;

(c) The participant's plan of care indicates he or she requires more hours of service than the program can provide, which may jeopardize the participant's safety and welfare due to being left alone without a caregiver present; or

(d) The participant, caregiver, family, or guardian threatens or intimidates a support broker or other PDS staff.

(8) The department may terminate a participant from PDS if it determines that the participant's PDS provider has not adhered to the plan of care.

(9) Except for an immediate termination as provided in subsection (7) of this section if a participant is to be terminated from PDS, the support broker shall:

(a) Notify the assessment or reassessment service provider of potential termination;

(b) Assist the participant in developing a resolution and prevention plan;

(c) Allow at least thirty (30) but no more than ninety (90) days for the participant to resolve the issue, develop and implement a prevention plan, or designate a PDS representative;

(d) Complete and submit to the department a MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS) terminating the participant from PDS if the participant fails to meet the requirements in paragraph (c) of this subsection; and

(e) Assist the participant in transitioning back to traditional HCB waiver services.

(10) Upon an involuntary termination of PDS, the department shall:

(a) Notify a participant in writing of its decision to terminate the participant's PDS participation; and

(b) Except if a participant failed to pay patient liability, inform the participant of the right to appeal the department's decision in accordance with Section 9 of this administrative regulation.

(11) A PDS provider shall:

(a) Be selected by the participant;

(b) Submit a completed Kentucky Consumer Directed Options/Participant Directed Services Employee/Provider Contract to the support broker;

(c) Be eighteen (18) years of age or older;

(d) Be a citizen of the United States with a valid Social Security number or possess a valid work permit if not a U.S. citizen;

(e) Be able to communicate effectively with the participant, participant representative, or family;

(f) Be able to understand and carry out instructions;

(g) Be able to keep records as required by the participant;

(h) Submit to the background and related checks established in Section 2(3)(p) of this administrative regulation;

(i) Not be a PDS provider excluded from providing services in accordance with Section 2(3)(q) of this administrative regulation;
(j) Prior to the beginning of employment, complete training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.030 and on the needs of the participant;
(k) Comply with the TB risk assessment and test requirements established in Section 2(3)(o)4 of this administrative regulation;
(l)
1. Obtain first aid certification within six (6) months of providing PDS services; and
2. Maintain first aid certification for the duration of being a PDS provider; and
(m)
1. Except as established in subparagraph 2 of this paragraph:
a. Obtain cardiopulmonary resuscitation (CPR) certification by a nationally accredited entity within six (6) months of employment; and
b. Maintain CPR certification for the duration of being a PDS provider; or
2. If the participant to whom a PDS provider provides services has a signed Do Not Resuscitate order, not be required to meet the requirements established in subparagraph 1 of this paragraph;
(n) Be approved by the department;
(o) Maintain and submit timesheets documenting hours worked; and
(p) Be a friend, spouse, parent, family member, other relative, employee of a provider agency, or other person hired by the participant.

(12) A PDS provider shall not provide more than forty (40) hours of PDS in a calendar week (Sunday through Saturday).

(13)
(a) The department shall establish a budget for a participant based on the individual's historical costs minus five (5) percent to cover costs associated with administering the participant-directed services. If no historical cost exists for the participant, the participant's budget shall equal the average per capita, per service historical costs of HCB recipients minus five (5) percent.
(b) Cost of services authorized by the department for the participant's prior year plan of care but not utilized may be added to the budget if necessary to meet the participant's needs.
(c) The department shall adjust a participant's budget based on the participant's needs and in accordance with paragraphs (d) and (e) of this subsection.
(d) A participant's budget shall not be adjusted to a level higher than established in paragraph (a) of this subsection unless:
1. The participant's support broker requests an adjustment to a level higher than established in paragraph (a) of this subsection; and
2. The department approves the adjustment.
(e) The department shall consider the following factors in determining whether to allow for a budget adjustment:
1. If the proposed services are necessary to prevent imminent institutionalization;
2. The cost effectiveness of the proposed services;
3. Protection of the participant's health, safety, and welfare; and
4. If a significant change has occurred in the participant's:
a. Physical condition resulting in additional loss of function or limitations to activities of daily living and instrumental activities of daily living;
b. Natural support system; or
c. Environmental living arrangement resulting in the participant's relocation.
(f) A participant's budget shall not exceed the average per capital cost of services provided to individuals in an NF.

(14) Unless approved by the department pursuant to subsection (13)(b) through (e) of this section, if a PDS is expanded to a point in which expansion necessitates a budget allowance increase, the entire service shall only be covered via a traditional (non-PDS) waiver service provider.

(15) A support broker shall:

(a) Provide any needed assistance to a participant with any aspect of PDS or blended services;

(b) Be available to a participant twenty-four (24) hours per day, seven (7) days per week;

(c) Comply with all applicable federal and state laws and requirements;

(d) Continually monitor a participant's health, safety, and welfare; and

(e) Complete or revise a plan of care using the person-centered planning principles established in Person Centered Planning: Guiding Principles.

(16)

(a) For a PDS participant, a support broker may conduct an assessment or reassessment; and

(b) A PDS assessment or reassessment performed by a support broker shall comply with the assessment or reassessment provisions established in Section 5(3)(a) and (b) of this administrative regulation.

Section 7. Use of Electronic Signatures.

(1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A home health provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, and contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 8. Applicability and Transition to HCB Waiver Version 2.

(1) The provisions and requirements established in this administrative regulation shall:

(a) Apply to HCB waiver services provided to an HCB waiver service recipient until the recipient transitions to the HCB waiver version 2; and

(b) Not apply to individuals receiving HCB waiver services version 2 pursuant to 907 KAR 7:010.

(2) An HCB waiver recipient receiving services pursuant to this administrative regulation shall transition to receiving services pursuant to 907 KAR 7:010 upon the recipient's next level-of-care determination if the determination confirms that the individual is eligible for HCB waiver services version 2.

(3)

(a) The provisions and requirements established in this administrative regulation shall become null and void at the time that the next level-of-care determination has been

performed regarding each participant currently receiving services via this administrative regulation.

(b) Next level-of-care determinations shall occur in accordance with 907 KAR 7:010, Section 4(2).

Section 9. Appeal Rights. An appeal of a department determination regarding NF level of care or services to a participant shall be in accordance with 907 KAR 1:563.

Section 10. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "Department for Medicaid Services Adult Day Health Care Services Manual", May 2005;

(b) "Department for Medicaid Services Home and Community Based Waiver Services Manual", September 2006;

(c) "Person Centered Planning: Guiding Principles", March 2005;

(d) "Technical Criteria for Reviewing Ancillary Services for Adults", November 2003;

(e) "MAP-24, Memorandum", August 2008;

(f) "MAP-95 Request for Equipment Form" June 2007;

(g) "MAP 109, Plan of Care/Prior Authorization for Waiver Services", July 2008;

(h) "MAP-350, Long Term Care Facilities and Home and Community Based Program Certification Form", July 2008;

(i) "MAP-351, Medicaid Waiver Assessment", July 2015;

(j) "MAP 2000, Initiation/Termination of Consumer Directed Option (CDO)/Participant Directed Services (PDS)", June 2015;

(k) "MAP-10, Waiver Services Physician's Recommendation", June 2015; and

(l) Kentucky Consumer Directed Options/Participant Directed Services Employee/Provider Contract, June 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

(9 Ky.R. 1180; eff. 5-4-1983; Recodified from 904 KAR 1:160, 5-2-1986; 13 Ky.R. 1512; eff. 3-6-1987; 18 Ky.R. 1640; eff. 2-7-1992; 24 Ky.R. 779; 1101; eff. 11-14-1997; 27 Ky.R. 3170; 28 Ky.R. 396; eff. 8-15-2001; 29 Ky.R. 1411; 1821; 2109; eff. 1-15-2003; 30 Ky.R. 456; 880; eff. 10-31-2003; 33 Ky.R. 1439; 2333; 3402; eff. 6-1-2007; 34 Ky.R. 1834; 2315; 2535; eff. 7-7-2008; 42 Ky.R. 1655; 2376; 2479; eff. 4-1-2016; Cert. eff. 1-30-2023.)